



CACFP Enrollment Form

Department of Human Development
Box 2218
South Dakota State University
Brookings, SD 57007
(605) 688-5730 or 1-800-354-8238

All information must be completed

CHILD INFO:

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Birth Date: _____ Enrollment Date: _____ Sex: _____ Male _____ Female

PARENT INFO:

First Name: _____ MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Sex: _____ Male _____ Female Home Phone: (____)____-____ Work Phone: (____)____-____

Email: _____ Over Night Stay Approved: _____ Yes _____ No

FORMULA OPTION:

FOOD OPTION:

____ Parent Supplies Breast Milk or Formula

____ Parent Supplies Additional Food and Refuses Provider's Foods

____ Parent Accepts Provider-Supplied Formula

____ Provider Supplies Additional Foods When Developmentally Appropriate

Name of Parent Formula: _____

Name of Provider Formula: _____

SCHOOL INFO:

ETHNICITY:

RACE:

- | | | | | |
|----------------------|---------------------------|------------------------|-----------------------------|---|
| ____ School Age | ____ PM Kindergarten | ____ All Day Headstart | ____ Hispanic/Latino | ____ American Indian / Alaska Native |
| ____ Home School | ____ All Day Kindergarten | ____ AM Preschool | ____ Not Hispanic or Latino | ____ Asian |
| ____ All Year School | ____ AM Headstart | ____ PM Preschool | | ____ Black or African American |
| ____ AM Kindergarten | ____ PM Headstart | ____ All Day Preschool | | ____ Native Hawaiian / Pacific Islander |
| | | | | ____ White |

School Name: _____

School Depart Time: _____ : _____ AM / PM Return Time: _____ : _____ AM / PM

Days Attending School: ____MON ____ TUE ____ WED ____THU ____ FRI

CHILD ATTENDANCE:

I anticipate the Days my child will participate will be: ____MON ____TUE ____ WED ____THU ____FRI ____SAT ____SUN ____ Days will vary

Drop Off Time _____ : _____ AM / PM Pick Up Time _____ : _____ AM / PM _____ Times will vary

I anticipate the Meals my child will participate will be: ____Breakfast ____AM Snack ____ Lunch ____PM Snack ____ Dinner ____ Evening Snack

RELATIONSHIP TO PROVIDER:

OTHER:

- | | | | |
|----------------------------|--------------------------|----------|---------|
| ____ Not related | Special needs Child | ____ Yes | ____ No |
| ____ Related, non-resident | Special diet | ____ Yes | ____ No |
| ____ Own Child | If special diet, explain | | |
| ____ Helper's Child | _____ | | |
| ____ Foster Child | _____ | | |

Provider Printed Name: _____

Provider Signature: _____ Parent Signature/Date: _____

In accordance with Federal Law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, write USDA Director, Office of Civil Rights, 1400 Independence Avenue SW, Washington, DC 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.